



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Robert E Urrea MD

Respondent Name

Southeastern Freight Lines Inc

MFDR Tracking Number

M4-17-0402-01

Carrier's Austin Representative

Box Number 48

MFDR Date Received

October 17, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We disagree with the denial. Our office submitted a pre-authorization request through Coventry. On December 15, 2015 we received a response authorizing a lumbar facet injection, procedure 64493, with a start date of 11/30/15 and end date of 02/26/16."

Amount in Dispute: \$239.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the attached MDR initial letter below."

Response Submitted by: Gallagher Bassett Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 17, 2015	64493, 77003	\$239.66	\$178.29

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the ambulatory surgical center fee guideline.
3. 28 Texas Administrative Code §134.600 sets out the requirements for prior authorization.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 39 – The services denied at the time authorization/pre-certification was requested
 - BL – To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of the EOR or clear notation that a rec

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule that pertains to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of \$239.66 for Codes 64493 – "Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level" and 77003 – "Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural or subarachnoid.)"

The submitted medical bill indicates place of service "24" or Ambulatory Surgical Center.

The insurance carrier denied disputed services with claim adjustment reason code 39 – "Services denied at the time authorization/pre-certification was requested." Prior authorization requirements are found in 28 Texas Administrative Code §134.600(p)(12) which states in pertinent part,

Non-emergency health care requiring preauthorization includes:

outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;

Review of the submitted documentation finds:

- Document with date December 15, 2015: Requested Service Description – 64493, "the requested treatment reference above has been reviewed by Coventry Health Care Workers Compensation, Inc. (Coventry) and has been determined to be medically necessary.

Based on the above the Division finds the requirements of Rule 134.600 (p)(12) were met. Therefore, the carrier's denial is not supported thus the services in dispute will be reviewed per applicable rules and fee guidelines.

2. The physician who performed the procedure has requested medical fee dispute. Therefore the applicable rule in determining the fee is 28 Texas Administrative Code 134.203(c)(1) which states,

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor.) For Surgery when performed in a facility setting, the established conversion factor to be applied is (date of service yearly conversion factor.)

The maximum allowable reimbursement calculation is below:

DWC Conversion Factor/Medicare Conversion Factor x Medicare Allowable = Texas Fee MAR or

For code 64493 - (70.54/35.9335) x \$90.82 = \$178.29

28 Texas Administrative Code 134.203(b)(1) states in pertinent part,

For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

Regarding code 77003. Per Medicare policy, procedure code 77003 should not be reported with the procedure code 64493 unless supported by correct use of a modifier to over-ride this relationship.

Review of the submitted medical claim found the following modifiers:

26 – “Professional Component / *Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number*” and

59 – “*Distinct Procedural Service/ Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.*”

Review of the submitted medical claim supports the use of the “26” modifier. However, review of the submitted “Operative Report” of December 17, 2015 found insufficient evidence to support the 59 modifier or “a separate or different procedure.” Therefore, no additional payment recommended.

3. Based on the applicable Division fee guidelines, the total amount allowed is \$178.29. This amount recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$178.29

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$178.29, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	December 19, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.